STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Dear Provider,

Thank you for your participation in the Rhode Island Medical Assistance Program. Enclosed are the forms and information necessary to enroll as a provider. These are:

- Enrollment Application with Instructions **(Mandatory)**
- Provider Agreement **(Mandatory)**
- W-9 form **(Mandatory)**
- Authorization for Direct Deposit **(Mandatory)**
- Enrollment Questionnaire **(Mandatory for Out-of-State Providers Only)**
- Current copy of your practice's form of licensure **(Mandatory)**
- Rates and Revenue Codes Sheet **(Mandatory - Hospital Providers)**

Completed enrollment forms should be mailed to:

EDS
Provider Enrollment Unit
P.O. Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at **1-800-964-6211**.

Sincerely,
Provider Relations

Attachments

ENROLLMENT FORM DIRECTIONS

Check the *New Provider* box (top left of the form) if this is the first time you have ever enrolled with the Rhode Island Medical Assistance Program.

Check one of the boxes at the top right of the form, as appropriate: "Individual Provider" (bills for services not performed under a *group provider* number)*;* "Individual Within A Group" (reimbursed for services by the *group provider*); or "Group Provider" (bills for the services of the *individual providers* within the group).

For *Group Applications*, list on a separate sheet of paper each individual group member's name, specialty, Medical Assistance provider number, license number and UPIN number. Each member of your group must be separately enrolled. Send one application for the group signed by the owner/administrator, and one application for each member of the group signed by the individual member. Be sure to include a copy of the current license or certification letter for each group member.

1. **PROVIDER NAME -** Enter your individual or group provider name exactly as it is entered on the attached W-9 form. **This is the name you will use to bill the program.**

2. **BUSINESS NAME** - Enter the name you will be doing business as, if different from above.

3. **ADDRESS -** Enter the complete physical address of the location where business or service is conducted. **P.O. Box alone is not acceptable as a service location.**

4. **TELEPHONE -** Enter the area code and telephone number of the location where business or service is conducted.

5. **SOCIAL SECURITY NUMBER (SSN) *or* FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) -** Enter your individual Social Security Number (9 - digits) *or* your individual or group FEIN (9 - digits).

> **NOTE: Enter either the SSN or FEIN but not both.** Individual and group providers must enter the same name/SSN or name/FEIN combination as was entered on the original W-9 form.

6. **OWNER/ADMINISTRATOR NAME -** Enter the name of the owner or administrator of your business or facility. Please indicate by checking **O** for the owner or **A** for the administrator.

7. **CURRENT MEDICAL ASSISTANCE PROVIDER TYPE AND PROVIDER NUMBER -** If you currently bill for Medical Assistance services, enter your Medical Assistance provider type and provider number.

8. **PROVIDER TYPE & SPECIALTY -** Enter the appropriate Provider Type and Specialty, e.g., MD - Internist; DDS - Oral Surgeon.

9. **NUMBER OF LICENSED AND SWING BEDS -** If applicable, enter the number of licensed and swing beds in your facility.

10. **EMC BILLER -** If you intend to bill via electronic media, check the appropriate box and complete the *Billing Application and Agreement for Electronic Billing* form (attached).

11. **LICENSE OR CERTIFICATION NUMBER -** If you are required to be licensed to provide services, enter your license or certification number. **A copy of the current valid license**

or certification letter must be submitted with the application. Group applications must include a valid copy for each member of the group. All group members must be individually certified by the Medical Assistance Program. (*At the time of renewal, a copy of the renewed license or certification letter must be sent so that the provider can continue as an active provider in the Medical Assistance Program*.) Hospitals must include a Rates and Revenue Codes sheet with the application.

12. **MEDICARE PIN NUMBER AND UPIN -** Enter the Medicare Provider Identification Number. If this application is for an individual physician or physician within a group, enter the physician's UPIN as well.

13. **CLIA NUMBER -** For clinical labs, enter the Clinical Laboratory Improvement Act (CLIA) number found on the CLIA Certificate of Compliance issued by HCFA. Include the documentation showing the specialties for which you are certified to bill.

14. **GROUP(S) MEMBERSHIP** - If you are a member of a group(s), enter the group(s) Medical Assistance provider number(s).

15. **PAY TO ADDRESS -** Must be the same as on the W-9 form. If you want your check sent to an address different from the one on your W-9, write your provider name; then on the next line write "c/o" and the name and address to which you want it sent.

16. **MAIL TO ADDRESS -** Indicate the address where all other program information should be sent.

17. **BILLING SERVICE ADDRESS -** If using an outside billing service, enter the address and telephone number of your billing service.

18. **FISCAL YEAR END DATE -** Enter the month in which your fiscal year ends.

19. **ADDITIONAL PRACTICE LOCATIONS** - Enter the address(es) and telephone number(s) of all other practice locations. If necessary, continue the list on a separate sheet of paper.

20. **HOSPITAL BASED EMPLOYEE -** If you answer yes, please include a copy of your contract with the facility.

21. **SELF-EXPLANATORY**

22. **DATE OF SERVICE (Out-Of-State Providers Only) -** Enter the date of service for the first encounter with a Rhode Island Medical Assistance recipient.

23. **PROVIDER SIGNATURE AND DATE -** Application must be signed by the Individual Applicant, or if a group or facility by the Senior Partner or CCO, along with the date of signature. **Stamped or photocopied signatures are not acceptable.**

    If the applicant is an entity other than an individual or group practice, please provide the following information on a separate sheet of paper:

    a. the name and address of each person who holds, directly or indirectly, an ownership interest as defined by 42 CFR 455.101, in the entity of, totaling more than five percent;

    b. whether or not any of the above-mentioned persons are related to one another as spouse, parent, child, or sibling;

    c. the name of any other entity required to make disclosure in which the persons described in paragraph (a) have an ownership interest:

d. each person or entity holding an interest of more than five percent in any of the following:

any mortgage, deed of trust, note or other obligation secured in whole or in part by the entity or any of the property or assets thereof, if the interest represents at least five percent of the value of the property or assets of the entity.

EDS / Provider Enrollment Unit, P.O. Box 2010, Warwick, RI 02887-2010

Requests for updates to your provider file, such as name or address changes, must be signed by the provider or authorized administrator and sent to the address above.

An incomplete application will be returned for completion.
Avoid this delay by submitting a complete application.

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
PROVIDER ENROLLMENT FORM

· New Provider

· Individual Provider
· Ind. Within Group
· Group Provider

Provider Number	Link ID	(Shaded Area for EDS use only)

Name Type_____
Census Tract_____
Cnty Code_____
Town Code_____
Location_____

1. Provider Name _____

2. Business Name _____

3. Address _____

Address _____

City _____State_____ Zip_____

4. Telephone: Area (_____)Number_____

5. Social Security Number _____ ***or*** FEIN _____

6. Owner/Administrator Name **O** ___ **A** ___ _____

7. Current Medical Assistance Provider Type/Provider Number _____

8. Provider Type _____

Speciality_____

9. Number of Licensed Beds _____

Number of Swing Beds _____

10. EMC Biller: Yes ___ No ___

11. License or Certification Number _____

12. Medicare PIN Number _____ ***and*** UPIN _____

13. CLIA Number _____

14. R.I. Medical Assistance ID Numbers of any groups to which you belong _____

(Continued on Back)

15. Pay to Address

_____

_____

16. Mail to address

_____

_____

17. Billing Service Address

_____

_____Phone #_____

18. Fiscal Year End Date_____

19. Additional Practice Locations

_____ _____

_____ _____

Phone Number_____ Phone Number_____

_____ _____

_____ _____

Phone Number_____ Phone Number_____

20. Are you a Full or Part-time Salaried Employee of a Hospital or Institution? Yes___ No___
If Yes, Name of Facility:_____

21. Are you or any Member of the Group the Subject of a Federal Exclusion Under 42 CFR? Yes___ No___
If Under yes, Please List (a) Date of Issuance, (b) Duration, (c) Name of Proposed Group Member**:** _____

22. Date of Service_____

23. This is to certify that the foregoing information is true, accurate , and complete understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Provider Signature _____Date_____